### PHLN Year 2 Project Aim

**Food Insecurity AIM Statement:**
We will effectively address high-priority social needs of our patients to improve clinical outcomes by *linking at least 25%* of patients seen in Phase 1 Primary Care sites who screen positive for *food insecurity* to appropriate resources by December 31, 2019.

### Measures for Success

**Process:**
- Percent of total Phase 1 Site staff trained on Food Insecurity
- Percent of total Phase 1 Site nursing/social work staff trained on workflows
- Percent of patients seen in Phase 1 Sites (Primary Care) that are:
  - Screened for FI
  - Screened positive for FI
  - Referred to resources
  - Follow attempt was made

**Outcomes:**
- Percent of patients who screened positive that were *linked* to resources
- Percent of patients screened and enrolled in Cal-Fresh
- Percent of patients linked to resources whose needs were met

**Balance:**
- Cycle time
- Patient experience data
Changes

Tested Changes

• Observations conducted of local workflows for food insecurity screening and referral at Phase 1 sites.

• A “pop-up” window was developed and tested for documenting follow-up actions for positive screens.

• We are creating a “toolkit” based on the observations and testing which will include screening/referral/linkage workflows, local food resources, scripts for clinic staff, guidelines for EMR documentation, etc.

Implemented Changes

• The Hunger Vital Sign was built in our EMR in the nursing intake under a new “Social Needs” tab.

• Food insecurity screening initiated at all Phase 1 sites using the Hunger Vital Sign.

• A report to query number of screenings performed and number of positive screens was built.

• A registry was built that lists patients with positive screens.
Workflow Observation Tool:

**PHLN Food Insecurity Workflow Observation**

**DATE/TIME:**

**LOCATION:**

**CLINIC:**

**OBSERVER:**

**Areas of Focus:**

1. Information and Data Systems (documentation, referral, spreadsheets, etc.):

2. Planned Care and Delivery (intake, referral, etc.):

3. Patient Engagement:

4. Community Linkages:

Social Work and/or Patient Exit Interview

**General Notes:**
### Using Data for Improvement

**Instructions:** Test in 5 patients who screen positive for either or both FI Screening questions.

- Test/Use with the Paper AdHoc pop-up to populate Column C.
- Perform Chart Review and/or patient outreach 2 weeks after positive screen to assess if patient accessed a recommended resource.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Patient Name</th>
<th>Patient MR #</th>
<th>FI Positive Screen Date</th>
<th>Staff Member acting on Pos Screen</th>
<th>Action for Positive Screen</th>
<th>Linked to Resource after 2 weeks?</th>
<th>Comments (please specify resource from Column F and/or G)</th>
</tr>
</thead>
<tbody>
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</table>

- **PDSA testing on patients who screen positive for Food Insecurity**

<table>
<thead>
<tr>
<th>Yes</th>
<th>Patient/Caregiver given handout on local food pantries and/or other community food resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Patient/Caregiver given CalFresh information sheet.</td>
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<tr>
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<td>PCP and/or Care Manager notified of positive FI screening.</td>
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<tr>
<td></td>
<td>Patient booked with Social Work/ Specialty request to Social Work order placed in ORCHID</td>
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<td>Warm handoff to designated support staff performed.</td>
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<td></td>
<td>Patient referred to Wellness Center.</td>
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<td>Patient declines resources and/or referral for FI resources at this time.</td>
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<tr>
<td></td>
<td>Other (please specify other or multiple actions in comments)</td>
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</table>
Using Data for Improvement

- FI Screening Rates by Facility
Using Data for Improvement

• FI Prevalence Rates by Facility
Strategies for Success

1. Convening leaders from different DHS facilities to develop and vet system-wide best practices
2. Testing with frontline users
3. Intentional planning around the training required for system-wide implementation
4. Ensuring the screening tools, registries, reports, etc. are built and integrated into the EMR
Key Tools & Resources

Hunger Vital Signs integrated into nursing intake
Key Tools & Resources

Patient answers “Yes” to one or both Hunger vital sign Food Insecurity (FI) Screening questions -> ad hoc pops up or dithered window appears in the Intake with the following documentation options:

- [ ] Patient/Caregiver given handout on local food pantries and/or other community food resources.
- [ ] Patient/Caregiver given CalFresh information sheet.
- [ ] PCP and/or Care Manager notified of positive FI screening.
- [ ] Patient booked with Social Work/ Specialty request to Social Work order placed in ORCHID.
- [ ] Warm handoff to designated support staff performed.
- [ ] Patient referred to Wellness Center.
- [ ] Patient declines resources and/or referral for FI resources at this time.
- [ ] Other: [Free Text Field]

EMR “Pop-up” window drafted to document follow up actions for positive Hunger Vital Sign screens.
### Key Tools & Resources

**Food Insecurity Registry:**

List of patients who screened positive for food insecurity by month.

Includes date of screen and contact information.

<table>
<thead>
<tr>
<th>Food Insecurity Complete</th>
<th>Food Insecurity Sometimes/Often True</th>
<th>Performed Date</th>
<th>Prim E</th>
<th>Prim M</th>
<th>PcrP</th>
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Current Challenges or Barriers

1. Inconsistent tracking and follow-up of FI positive screens which we are addressing through our efforts

2. Need to continue to promote systemwide adoption of FI screening at intake by nursing
Next Steps

**Spreading**

- Phase 2 will go-live with Food Insecurity screening in Spring 2020 utilizing the new toolkit.
- New Food Insecurity Report will be used to track monthly screening and prevalence rates for all DHS clinics.
- A standardized workflow using the registry for tracking and follow-up on positive screens will be developed.

**Sustaining**

- Identify and help support sites that have low rates of screening.
- Further identify community resources and enhance our ability to link patients to these resources.
- Celebrate successes and best practices!